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**Title:**

The prospective association between inflammation and depression in type 2 diabetes stratified by sex

**Running head:**

Inflammation and depression in type 2 diabetes

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## **Abstract**

### **Background**

We tested whether inflammation is associated with worsening depressive symptoms in type 2 diabetes and examined whether sex moderated this association.

### **Research Design and Methods**

In a prospective cohort study of people with newly diagnosed type 2 diabetes, we measured depressive symptoms over 2-year follow-up using the Patient Health Questionnaire-9 (PHQ-9). The independent variable was a composite inflammation burden score at diagnosis of diabetes, derived from high-sensitivity C-reactive protein, white cell count, interleukin (IL)-1 $\beta$ , IL-1 receptor antagonist, monocyte chemoattractant protein-1 and vascular endothelial growth factor concentrations. General linear models assessed i) the association between overall inflammation burden and estimated marginal mean PHQ-9 score (natural log (ln)-transformed) at 2 years; and ii) the interaction between elevated (above-median) inflammation burden and sex on ln-PHQ-9 score. Models were adjusted for age, ethnicity, body mass index, blood pressure, cholesterol, HbA<sub>1c</sub>, antidepressants, anti-inflammatory medications and baseline ln-PHQ-9 score.

### **Results**

Of 1174 people with complete inflammation data, mean age was 56.7 (11.0) years, 46.1% were of non-white ethnicity and 44.1% female. After full adjustment, inflammation burden was not associated with worsening ln-PHQ-9 score ( $p=0.65$ ). However, there was a significant interaction between sex and inflammation on 2-year ln-PHQ-9 score ( $\beta=0.32$ ,  $p=0.005$ ), showing that the difference by inflammation burden in females was 0.32 larger than in males. In post-hoc comparisons, ln-PHQ-9 score was higher in females than males with elevated inflammation ( $p=0.003$ ) but not with low inflammation burden ( $p=0.34$ ).

### **Conclusion**

In type 2 diabetes, female sex confers specific vulnerability to the effects of inflammation on depressive symptoms.

## **Introduction**

Depressive symptoms are reported by 10-30% of people with type 2 diabetes – twice as often as in the general population – and are associated with 1.5-3-fold increased frequency of diabetes complications and premature mortality.<sup>1-3</sup> In a psychological model of the association, depressive symptoms could be formulated as negative cognitions and emotions to the burden of a chronic disease, in turn leading to poor diabetes outcomes through reduced diabetes self-care.<sup>4</sup> This model, however, provides limited opportunities to understand disease mechanisms and improve outcomes. For example, in cohort studies, depressive symptoms are not always associated with worsening in glycaemic control over time,<sup>5</sup> suggesting that depression does not consistently lead to worsening diabetes self-care. In neuroimaging research, the brain changes typical of depression – such as hippocampal atrophy – mirror those seen in type 2 diabetes.<sup>6,7</sup> Moreover, the link is bidirectional: whereas type 2 diabetes is associated with increased risk of incident depressive symptoms, the converse association is even stronger.<sup>8</sup>

A unifying explanation for these observations is that depressive symptoms and type 2 diabetes are not distinct conditions, but rather may be linked by shared disease mechanisms, such as elevated inflammation.<sup>9</sup> In support, pro-inflammatory cytokines and elevated acute phase proteins are associated with onset of depression and type 2 diabetes, respectively,<sup>10,11</sup> whilst some anti-inflammatory therapies have demonstrated benefit in the two conditions separately.<sup>12,13</sup> To date, research testing inflammation as a link between depression and type 2 diabetes has been scarce. In cross-sectional studies in people with type 2 diabetes, those with comorbid depressive symptoms had higher concentrations of acute phase proteins and cytokines, even after adjustment for confounders such as body mass index (BMI), smoking, and age.<sup>14-16</sup> However, no prospective cohort study has tested the association between inflammation and the course of depressive symptoms over time in people with type 2 diabetes, such that potential causality cannot yet be inferred.

Like depressive symptoms, female sex is associated with increased risk of cardiovascular complications in people with type 2 diabetes, even accounting for sex differences in other major cardiovascular risk factors.<sup>17</sup> Depressive symptoms are also nearly twice as prevalent in females than males with established type 2 diabetes.<sup>18</sup> In depression research, female sex appears to increase vulnerability to the effects of inflammation on the brain,<sup>19</sup> and anti-

inflammatory diabetes treatments may improve depressive symptoms more significantly in females.<sup>20</sup> Collectively, this suggests that inflammation could lead predominantly to depressive symptoms in females with type 2 diabetes and further could provide an explanation for the poor overall prognosis of female diabetes.

Using an incident type 2 diabetes cohort, we therefore aimed to test the hypotheses that elevated inflammation is associated with worsening depressive symptoms in people with type 2 diabetes and secondly that this association is stronger in females than in males.

## **Research Design and Methods**

*Setting and study design:* The South London Diabetes (SOUL-D) study is a population-based prospective cohort of people with newly diagnosed type 2 diabetes recruited within six months of diagnosis and followed over 2 years.<sup>21</sup> The study was set in the inner-city boroughs of Lambeth, Southwark, and Lewisham in South London, which collectively have approximately 0.75 million residents from diverse ethnic- and socioeconomic backgrounds. All General Practice (GP) surgeries in these boroughs were invited to participate. Local protocols for diagnosis of type 2 diabetes followed World Health Organisation criteria.<sup>22</sup> Ethical approval was granted by the King's College Hospital Research Ethics Committee (reference 08/H0808/1) and by Lambeth, Southwark, and Lewisham Primary Care Trusts (reference RDLSLB 410). All participants gave written informed consent, including for access to their medical records. Details of inclusion criteria and recruitment timetable have been published.<sup>21</sup>

*Outcomes:* The outcome at 2-year follow-up was depressive symptoms, as measured by total Patient Health Questionnaire-9 (PHQ-9) score. Due to positive skew, we natural log-transformed PHQ-9 scores. As discussed previously, the PHQ-9 is a 9-item questionnaire based on the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) diagnostic criteria for clinical depression, which has been validated for use in people with type 2 diabetes.<sup>23</sup> Missing PHQ-9 data (where <20% of responses were missing) were imputed using case mean substitution, discussed in detail previously.<sup>5</sup>

*Independent variable:* The independent variable was a composite measure of inflammation burden based on six markers of inflammation: high-sensitivity C-reactive protein (hs-CRP),

interleukin-1 $\beta$  (IL-1 $\beta$ ), IL-1 receptor antagonist (IL-1RA), monocyte chemotactic protein-1 (MCP-1), vascular endothelial growth factor (VEGF), and white blood cell count (WBC). As well as measuring a range of inflammatory pathways – including acute phase-, cytokine- and chemokine responses – these markers were selected because of their positive individual associations with depressive symptoms in the baseline SOUL-D cohort.<sup>14</sup> As in previous research,<sup>24</sup> a composite inflammation burden score was calculated by transforming each measure into a z-distribution, whose mean is 0 and standard deviation is 1, before averaging the individual biomarker z-scores. This approach minimises multiple testing and reduces the influence of the biological variability of each measure. Serum hs-CRP was measured using an Advia 2400 analyzer (Siemens Diagnostics, Frimley, UK) with detection limit 0.1 mg/L; WBC was measured using an Advia 2120 analyzer (Siemens Diagnostics); and IL-1 $\beta$ , IL-1RA, VEGF and MCP-1 were measured from serum samples centrifuged from venous blood samples taken after an overnight fast, stored between –40 and –80°C using cytokine-array biochip kits (Randox, Belfast, UK) and analyzed using the Randox Evidence Investigator; the inter- and intra-assay coefficients of variation for all analytes measured using these kits are <15 and <10%, respectively.

*Confounders:* We considered the following potential confounders *a priori*: age, ethnicity (white versus non-white), BMI, blood pressure, smoking status, HbA<sub>1c</sub> (measured by affinity chromatography [Primus Ultra2, Kansas City, USA]), serum total cholesterol (measured using Siemens Advia 2400 Analyzer, detection limit 0.01 mmol/L), prescription of any anti-inflammatory medications (systemic steroids, nonsteroidal anti-inflammatory drugs [NSAIDs]) and antidepressant medications.

## **Statistical analyses**

*Baseline analysis:* Data were analysed using IBM SPSS version 25.0. We compared the following baseline characteristics of the cohort stratified by low- or elevated inflammation burden at baseline: sociodemographic variables (age, self-report ethnicity [African/Caribbean, white, South Asian/other]); baseline biomedical variables (smoking status, total cholesterol, BMI, HbA<sub>1c</sub>, inflammatory markers, anti-inflammatory medications, antidepressant medications, blood pressure, inflammatory marker concentrations); and baseline PHQ-9 score. For continuous variables, we used Student's t-test for normally distributed data and the Mann-Whitney U test for skewed data, and for categorical variables

we used chi-square tests. Results were presented as mean (SD) or median (interquartile range) for skewed data, unless otherwise stated. Compared to those included in the analysis, we assessed the characteristics of people missing inflammation data at baseline.

*Prospective association between inflammation burden and depressive symptoms:* the prospective analysis comprised unadjusted- and adjusted general linear models in which the outcome was 2-year PHQ-9 score (natural log-transformed). We firstly tested whether elevated inflammation burden (total inflammation z-score) was associated with elevated PHQ-9 score at follow-up in the whole cohort after adjustment for baseline PHQ-9 score. We next adjusted the model for the range of potential confounders. Associations were reported using the standardised beta coefficient and its associated p-value.

*Interaction between inflammation and sex on course of depressive symptoms:* We next used general linear models to test the interaction between sex and inflammation burden on 2-year PHQ-9 score. We firstly measured the beta-coefficient of the interaction, which presents the difference in PHQ-9 score between low- and elevated inflammation status in females compared to males. We next interrogated the directionality of any interaction using the estimated marginal mean (EMM) difference in PHQ-9 score at follow-up by comparing the differences in PHQ-9 score between females and males within the low- and elevated inflammation groups. Estimated marginal means are presented at mean values for each covariate (rather than resetting them to 0, as in linear regression models), which provides a clinically relevant measure of the association between inflammation and depression course in a typical patient (in this case a patient with average baseline depression score and average score or average proportion for other covariates and categorical variables respectively). The unadjusted interaction model comprised the outcome 2-year PHQ-9 score (natural log-transformed) and the independent variables of sex, inflammation status, sex\*inflammation status, and baseline PHQ-9 score. We next adjusted the model for the full range of confounders. Interactions were also displayed graphically.

*Sensitivity analyses:* To account for missing data, we performed multiple imputation analyses with 20 multiply imputed datasets. Incomplete variables were imputed under fully conditional specification, using iterative Markov chain Monte Carlo (MCMC) estimation method. All variables were included in the imputation process, including interactions between PHQ-9 score (ln-transformed) and sex at both time points. The parameters of



interest were estimated in each imputed dataset separately and combined using Rubin's rules.<sup>25</sup> Finally, to account for participants who may have had elevated inflammation due to an acute infection, we conducted a further sensitivity analysis excluding those with hs-CRP concentration >10mg/L at baseline.<sup>26</sup>

## **Results**

Ninety-six out of 136 (70.6%) GP surgeries agreed to participate. From their diabetes registers, a target population of 3008 newly-diagnosed type 2 diabetes patients were identified, of whom 2406 people were potentially eligible and invited to participate, and of whom 1735 people consented. Of these, 1174 (67.7%) provided complete data on all 6 inflammatory markers and were included in the current analysis. The mean age of this subset was 56.7 (11.0) years, 44.1% were female and 46.1% of non-white ethnicity.

Compared with those included in the analysis, those with missing inflammation data were younger (55.0 [11.0] versus 56.7 [11.0] years,  $p=0.003$ ), had slightly higher BMI (32.5 [6.7] versus 31.8 [6.4] kg/m<sup>2</sup>,  $p=0.032$ ), slightly lower total cholesterol (4.50 [1.1] versus 4.62 [1.1] mmol/L,  $p=0.044$ ), higher baseline depressive symptoms (3 [1-7] versus 2 [0-6],  $p=0.009$ ), were more often of non-white ethnicity (65.0% versus 48.7%,  $p<0.001$ ), smokers at baseline (24.5% versus 19.0%,  $p=0.011$ ), and less likely to be prescribed NSAIDs/steroids (23.2% versus 30.0%,  $p=0.003$ ), or antidepressants at baseline (1.2% versus 7.3%,  $p<0.001$ ). However, there were no differences in proportion of female sex ( $p=0.14$ ), baseline HbA1c ( $p=0.21$ ), BMI ( $p=0.99$ ), systolic blood pressure ( $p=0.47$ ) or diastolic blood pressure ( $p=0.89$ ) (test statistics not shown).

*Baseline comparisons:* Compared to those with low inflammation burden, people with elevated inflammation burden were older, had higher BMI, higher total cholesterol, higher hs-CRP, higher baseline PHQ-9 score, were more often of African/Caribbean ethnicity than white, smokers at baseline, and prescribed antidepressant medication. There were no differences by inflammation burden in sex, South Asian ethnicity, blood pressure, glycaemic control and prescription of anti-inflammatory medication (Table 1).

[Insert Table 1 here]

*Follow-up:* A total of 803 (68.4%) of people provided both inflammation and 2-year PHQ-9 data. Compared to those followed up, people with missing data were younger (55.1 [11.6] years versus 57.4 [10.7] years,  $p=0.001$ ), more likely to be female (49.1% versus 41.8%,  $p=0.021$ ), of non-white ethnicity (52.8% versus 43.0%,  $p=0.002$ ), to have low inflammation burden (56.1% versus 46.6%,  $p=0.002$ ), had higher baseline HbA1c (7.14 [1.5] versus 6.90 [1.4],  $p=0.006$ ), and higher baseline diastolic blood pressure (84.0 [11.2] versus 82.6 [10.4],  $p=0.04$ ). However, there were no differences by attrition in proportion of smokers ( $p=0.64$ ), prescription of NSAIDs/steroids at baseline ( $p=0.34$ ), prescription of antidepressants at baseline ( $p=0.73$ ), baseline BMI ( $p=0.13$ ), baseline systolic blood pressure ( $p=0.55$ ), baseline total cholesterol ( $p=0.98$ ) and baseline total PHQ-9 score ( $p=0.84$ ) (test statistics not shown).

*Prospective association between inflammation burden and course of depressive symptoms:* Before or after full adjustment, there was no association between inflammation burden at baseline and higher PHQ-9 score at 2 years in the whole cohort (Table 2).

[Insert Table 2 here]

*Unadjusted interaction between inflammation burden and sex on course of depressive symptoms:* In the unadjusted general linear model, there was a significant interaction between female sex and elevated inflammation burden on change in PHQ-9 score ( $\beta = 0.36$ ,  $p=0.001$ ), meaning that the difference between low- and elevated inflammation status was 0.36 larger in females compared to males (Table 2). A post hoc analysis of the interactions revealed no differences in depressive symptoms between males and females with low inflammation burden (EMM difference = 0.07,  $p=0.37$ ), whilst depressive symptoms were significantly higher in females than males in the subgroup with elevated inflammation burden (EMM difference = 0.29,  $p<0.001$ ) (Table 3, Figure 1a).

[Insert Table 3 and Figure 1 here]

*Adjusted interaction between inflammation burden and sex on depressive symptoms:* After adjustment for the full range of confounders, including baseline depressive symptoms, the interaction remained significant ( $\beta=0.32$ ,  $p=0.005$ ): the difference between low- and elevated inflammation burden in females was 0.32 larger than in males (Table 2). Post hoc pairwise comparisons again showed that there was no significant difference between males and

females in the low inflammation group (EMM difference = 0.08,  $p=0.34$ ), whereas females had higher depressive symptoms than males in the elevated inflammation group (EMM difference = 0.23,  $p=0.003$ ), conditioned on average values of covariates (Table 3, Figure 1b).

*Sensitivity analyses:* Using multiple imputation for missing data did not alter the conclusions: the unadjusted interaction ( $\beta = 0.36$ ,  $p<0.001$ ) and fully adjusted interaction ( $\beta = 0.31$ ,  $p<0.001$ ) between female sex and elevated inflammation remained strongly significant. Supplemental Table 1 shows the full breakdown of unadjusted- and adjusted interactions after multiple imputation. Exclusion of the 147 people with baseline hs-CRP  $>10\text{mg/L}$  – potentially indicating acute infection – likewise did not alter the conclusions: the fully adjusted interaction remained significant ( $\beta = 0.31$ ,  $p=0.009$ ) and females had higher depressive symptoms than males in subgroup with elevated inflammation (EMM difference = 0.24  $p=0.007$ ).

[Insert Supplemental Table 1 here]

## **Discussion**

In a prospective cohort study of people with newly diagnosed type 2 diabetes recruited from primary care, elevated inflammation at diagnosis of type 2 diabetes – as estimated using a composite measure of acute phase, cytokine and chemokine markers – was not associated with worsening depressive symptoms over 2 years. However, elevated inflammation burden was associated with greater worsening depressive symptoms in females compared to males. These findings remained robust to adjustment for a range of pro-inflammatory and anti-inflammatory confounders, including BMI and smoking status.

*Comparison with previous literature:* Depressive symptoms are commonly reported in people with type 2 diabetes and are associated with poor biomedical outcomes.<sup>1,2</sup> In addition to psychological and behavioural factors, there is increasing evidence that biological mechanisms may provide a link between depressive symptoms and type 2 diabetes. In particular, previous studies have demonstrated a cross-sectional association between elevated inflammation and depressive symptoms in people with type 2 diabetes,<sup>14,15</sup> although no cohort study has tested this prospectively. Our study therefore marks a clear advance in the

literature by demonstrating that inflammation is associated with preferential worsening in depressive symptoms in females compared to males with type 2 diabetes.

Although depressive symptoms are nearly twice as prevalent in females with type 2 diabetes compared to males,<sup>18</sup> the reasons for this predominance are poorly understood. A possible explanation is that females are more likely to report depressive symptoms than males, for example due to different social processes influencing presentation of psychological distress for the different sexes. However, this is not supported by the similar reporting of depressive symptoms between males and females with low burden of inflammation in our study. Likewise, adjustment for increased BMI – another possible reason for female vulnerability to depression<sup>27</sup> – did not attenuate our findings.

Echoing prospective findings from the general population,<sup>28,29</sup> our results suggest that worse depressive symptoms in females with type 2 diabetes could result from elevated inflammation. This is likely to occur through dialogue with dysfunction of the hypothalamic-pituitary-adrenal (HPA) axis. Specifically, activation of the HPA axis by stress should normally lead to an increase in glucocorticoid sensitivity, enabling cortisol to inhibit- and thus regulate inflammatory responses. Whereas males demonstrate this response consistently, stress appears to exert the opposite effect in females, leading to decreased glucocorticoid sensitivity and exaggerated inflammatory responses.<sup>30</sup> Notably, females in our sample were typically of postmenopausal age, by which time HPA axis dysfunction has become most pronounced, probably due to loss of modulation by gonadal steroids.<sup>31</sup> The presence of a dysfunctional HPA axis thereby exposes females to exaggerated effects on inflammation, leading to increased risk of cardiovascular disease in the periphery and potentially an increased risk of depression centrally.<sup>32,33</sup> Central effects may occur through pro-inflammatory cytokines activating the enzyme indoleamine 2,3-dioxygenase, which diverts tryptophan metabolism from serotonin towards neurotoxic metabolites in the brain.<sup>33</sup>

*Interpretation:* Our findings suggest that depressive symptoms and female sex – both poor prognostic factors in type 2 diabetes respectively – are biologically linked by inflammation. The result is an ‘inflammatory depression’ that predominantly affects females, runs a persistent course and is poorly explained by lifestyle factors such as smoking and obesity. Both female sex and inflammation are strongly associated with cardiovascular risk in type 2

diabetes,<sup>17,32</sup> and notably the typical hs-CRP concentration for the elevated inflammation group in our study was in the range for high cardiovascular risk.<sup>26</sup> As such, the inflammatory depression of female type 2 diabetes could be an important and potentially modifiable biomarker of future cardiovascular disease and mortality, which requires testing over longer-term follow-up.

Therapeutically, the strong association between female sex and inflammation suggests a need to ‘gender’ therapy towards reducing the burden of inflammation in females. For example, in managing depression, elevated innate inflammation is associated with poor response to the usual first-line antidepressants: selective serotonin reuptake inhibitors (SSRIs).<sup>34</sup> In females with depressive symptoms, clinicians may therefore consider proactive switching to antidepressants that have greater anti-inflammatory properties, such as tricyclic antidepressants.<sup>34</sup> Likewise, within the repertoire of current diabetes treatments, females with type 2 diabetes could be treated earlier with therapies known to have greater anti-inflammatory properties. For example, incretin-based therapies and thiazolidinediones have potent effects on inflammation,<sup>35,36</sup> and could even be a novel treatment for depression by modifying inflammation.<sup>20</sup>

As well as repositioning of anti-inflammatory diabetes treatments, our results support trials of anti-inflammatory agents for depressive symptoms in type 2 diabetes, which have not yet been performed. In the general population, anti-inflammatory- and HPA-axis modifying therapies have demonstrated inconsistency in improving depressive symptoms,<sup>12,37</sup> and our findings suggest that benefit would be maximised by specifically recruiting females to such clinical trials. Future experimental medicine studies are needed to profile the dynamic immune responses conferring vulnerability to female depressive symptoms in type 2 diabetes, thereby providing clearer targets for interventional studies. A better understanding of the bidirectional interplay between the HPA axis and inflammation is required, including predisposing factors to HPA axis dysfunction, such as changes in gonadal hormones. Finally, lifecourse epidemiological research is needed to delineate the temporal relationship between inflammation, depression and type 2 diabetes, as well as possible upstream aetiologies such as stressful life events.

*Strengths and limitations:* our study is strengthened by its unique multi-ethnic and socioeconomically diverse cohort, which is representative of the global type 2 diabetes population. By recruiting all patients within 6 months of diagnosis of type 2 diabetes, confounding effects of diabetes complications on inflammation and depression were minimised. A composite measure of inflammation that included acute phase, cytokine and chemokine responses provided a broad yet rigorous test of inflammation. Our data were limited by 32% missing values for inflammation burden at baseline, although there were no sex differences between those missing data and those included. Although a similar attrition rate over 2 years is a further limitation of our study, maximising follow-up is particularly challenging in an urban population with high rates of social deprivation, multimorbidity, geographical mobility, and a primary care setting in which several GP surgeries closed during the study. Furthermore, multiple imputation of missing data resulted in no significant changes to the study findings. We did not assess for periodontitis, which could be an important cause of inflammation, depression and type 2 diabetes.<sup>38,39</sup> We measured depressive symptoms continuously using a validated self-report questionnaire, which will likely over-identify depressive symptoms compared to a diagnostic interview. However, there is strong evidence that subthreshold depressive symptoms are prognostically important in people with diabetes.<sup>40</sup> Finally, longer follow-up is needed to confirm the persistence of inflammatory depression in females, as well as associated biomedical sequelae.

## **Summary**

In the early stages of type 2 diabetes, inflammation shows no overall association with worsening in depressive symptoms over 2-year follow-up. However, inflammation demonstrates a preferential association with worsening depressive symptoms in females compared to males, which is not explained by potential confounders such as obesity. Future studies should test whether inflammation is a modifiable target for reducing the gender gap in psychological- and biomedical outcomes in people with type 2 diabetes.

## **Figure captions**

Figure 1: General linear model testing the interaction between sex and inflammation burden on the 2-year course of depressive symptoms in the SOUL-D cohort: a) adjusted only for baseline depressive symptoms; b) adjusted for baseline depressive symptoms and the full range of confounders.

### **Author contributions**

S.A.A and K.I conceived the South London Diabetes Cohort. C.D.M, D.S, J.C.P and K.I designed the current manuscript and C.D.M wrote the first draft. C.D.M, D.S and A.R performed the statistical analyses. All authors revised the manuscript for important intellectual content. C.D.M is the guarantor of this work and, as such, had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

### **Declarations of interest**

J.C.P reports consultancy and/or speaker fees from Insulet, Medtronic, Roche and Theras. K.I reports speaker fees from Eli Lilly, Janssen, Novo Nordisk and Sanofi. C.D.M, A.R, S.A.A and D.S report no potential dualities of interest.

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<b>Table 1: Baseline characteristics of the South London Diabetes cohort stratified by inflammation burden at baseline</b>					
<b>Variable</b>	<b>Category</b>	<b>Total cohort<sup>a</sup></b>	<b>Elevated inflammation burden<sup>a</sup> (n=592)</b>	<b>Low inflammation burden<sup>a</sup> (n=582)</b>	<b>p-value<sup>b</sup></b>
<b>Sociodemographic variables</b>					
Age, years (SD)		56.7 (11.0)	57.6 (10.9)	55.7 (11.0)	0.003
Sex (%)	Male	656 (55.9)	323 (54.6)	333 (57.2)	-
	Female	518 (44.1)	269 (45.4)	249 (42.8)	0.36
Ethnicity (%)	White	633 (54.0)	394 (66.6)	239 (41.1)	-
	African/Caribbean	417 (35.5)	124 (20.9)	293 (50.3)	<0.001 <sup>c</sup>
	South Asian/other	124 (10.6)	74 (12.5)	50 (8.6)	0.59 <sup>c</sup>
<b>Baseline vascular risk factors</b>					
Smoker status (%)	Smoker	216 (18.9)	152 (26.3)	64 (11.4)	-
	Non-smoker	924 (81.1)	427 (73.7)	497 (88.6)	<0.001
Mean BMI, kg/m <sup>2</sup> (SD)		31.8 (6.4)	32.6 (6.8)	30.9 (5.8)	<0.001
Mean systolic BP, mmHg (SD)		136.1 (17.4)	136.3 (17.5)	136.0 (17.3)	0.78
Mean diastolic BP, mmHg (SD)		83.0 (10.5)	83.1 (10.6)	82.8 (10.4)	0.61
Mean HbA1c, % (SD)		6.98 (1.4)	7.02 (1.4)	6.91 (1.4)	0.35
Mean HbA1c, mmol/mol (SD)		52.8 (10.6)	53.2 (10.6)	52.0 (10.5)	0.35
Mean total cholesterol, mmol/L (SD)		4.62 (1.1)	4.70 (1.1)	4.53 (1.0)	0.007
<b>Baseline inflammatory variables</b>					
Prescribed NSAIDs/opioids (%)	Yes	348 (30.0)	187 (31.9)	161 (28.0)	-
	No	814 (70.0)	400 (68.1)	414 (72.0)	0.15
Median hs-CRP [IQR]		2.7 [1.1-6.3]	4.6 [1.9-9.0]	1.6 [0.8-3.9]	<0.001
Median IL-1B [IQR]		1.02 [0.73-1.87]	1.16 [0.79-2.64]	0.91 [0.69-1.54]	<0.001
Median IL-1RA [IQR]		437.0 [290.0-695.8]	620.2 [399.4-916.0]	323.8 [223.1-473.4]	<0.001
Median MCP-1 [IQR]		102.3 [59.6-152.2]	138.7 [92.3-189.2]	72.3 [49.9-109.9]	<0.001
Median VEGF [IQR]		76.0 [45.6-118.1]	114.4 [82.1-163.7]	48.9 [33.1-71.7]	<0.001
Median WBC [IQR]		7.6 [6.4-9.0]	8.6 [7.4-10.1]	6.7 [5.7-7.7]	<0.001
<b>Baseline psychological variables</b>					
Median PHQ-9 score [IQR]		2 [0-6]	3 [1-7]	2 [0-6]	<0.001
Prescribed antidepressants (%)	Yes	84 (7.2)	53 (8.9)	31 (5.3)	-
	No	1089 (92.8)	538 (91.1)	551 (94.7)	0.016
<p>a) Inflammation burden comprises baseline concentrations of white cell count, interleukin-<math>\beta</math>, interleukin-1 receptor antagonist, high-sensitivity C-reactive protein, monocyte chemotactic protein-1 and vascular endothelial growth factor. Each concentration is z-transformed and all 6 measures are averaged to calculate an overall score. This is split by the median value to define elevated- and low inflammation burden. b) Parametric continuous data are presented as mean (SD) and compared using Student's t-test; non-parametric continuous data are presented as median [interquartile range] and compared using Mann-Whitney <i>U</i> test; categorical variables presented as frequency (%) and compared using chi-square tests. c) Compared to white ethnicity. Key: BMI, body mass index; BP, blood pressure; CRP, high-sensitivity C-reactive protein; NSAIDs, non-steroidal anti-inflammatory drugs; PHQ-9, patient health questionnaire-9; SD; standard deviation.</p>					

**Table 2: Multivariate analysis testing the associations between inflammation burden and sex on 2-year depressive symptoms in the SOUL-D cohort**

<b>Independent variables</b>			
<b>Model 1: inflammation as independent variable</b>		<b>Adjusted for baseline PHQ-9 score only</b>	<b>Fully adjusted<sup>a</sup></b>
Overall inflammation burden (continuous)	$\beta$ (95% CI), p-value	0.05 (-0.03 to 0.14), p=0.23	0.02 (-0.07 to 0.11), p=0.65
Inflammation burden (binary) (1=elevated, 0=low)	$\beta$ (95% CI), p-value	0.09 (-0.02 to 0.19), p=0.11	0.06 (-0.05 to 0.18), p=0.30
<b>Model 2: inflammation, sex and their interaction as independent variables</b>			
Inflammation burden (1=elevated, 0=low)	$\beta$ (95% CI), p-value	-0.06 (-0.20 to 0.08), p=0.37	-0.07 (-0.22 to 0.08), p=0.35
Sex (1=female, 0=male)	$\beta$ (95% CI), p-value	-0.07 (-0.23 to 0.09) p=0.37	-0.08 (-0.25 to 0.09), p=0.34
Interaction (female sex*elevated inflammation burden)	$\beta$ (95% CI), p-value	0.36 (0.15 to 0.57), p=0.001	0.32 (0.10 to 0.53), p=0.005
	Total number in model	N=797	N=706
Multivariable general linear models with outcome 2-year Patient Health Questionnaire-9 (PHQ-9) score (natural log-transformed). Reference groups are low inflammation burden, male sex, and low inflammation*male sex. a) Adjusted for baseline PHQ-9 score (log-transformed), age, non-white ethnicity, body mass index, baseline systolic blood pressure, baseline smoking status, baseline serum cholesterol, baseline HbA <sub>1c</sub> , prescription of anti-inflammatory medication and prescription of antidepressant medication. Key: CI, confidence interval			

**Table 3: General linear models testing the interactions between sex and inflammation burden on 2-year depressive symptoms in the SOUL-D cohort**

**i) Pairwise comparisons between males and females within low- and elevated inflammation groups: adjusted for baseline depressive symptoms only<sup>a</sup>**

Inflammation burden	(I) Sex	(J) Sex	Mean Difference (I-J)	Std. Error	Sig.	95% CI Lower Bound	95% CI Upper Bound
Low	Male	Female	-0.07	0.08	0.37	-0.23	0.09
Elevated	Male	Female	-0.29	0.07	<0.001	-0.43	-0.14

**ii) Pairwise comparisons between males and females within low- and elevated inflammation groups: fully adjusted<sup>b</sup>**

Inflammation burden	(I) Sex	(J) Sex	Mean Difference (I-J)	Std. Error	Sig.	95% CI Lower Bound	95% CI Upper Bound
Low	Male	Female	0.08	0.09	0.34	-0.09	0.25
Elevated	Male	Female	-0.23	0.08	0.003	-0.39	-0.08

Outcome is estimated marginal mean Patient Health Questionnaire-9 (PHQ-9) score (natural log-transformed) at 2 years. a) Adjusted only for baseline PHQ-9 score (natural log-transformed). b) Adjusted for baseline PHQ-9 score (natural log-transformed), age, non-white ethnicity, body mass index, baseline systolic blood pressure, baseline smoking status, baseline serum cholesterol, baseline HbA<sub>1c</sub>, prescription of anti-inflammatory medication and prescription of antidepressant medication. Key: CI, confidence interval.